EXHIBIT 9
DATE 3/11/09
HB 612

S&D Harr

From: "S&D Harr" <ssurelyl@worldnet.att.net>
To: "Sheri Heffelfinger" <Sheffelfinger@mt.gov>
Cc: "Shirley Harr" <ssurelyl@worldnet.att.net>
Sent: Monday, September 15, 2008 12:41 AM
Subject: Report to LJIC

My name is Donald Harr, M.D., a psychiatrist from Billings representing the Montana Psychiatric Association and the Suicide Prevention Coalition of Yellowstone Valley. My apology is extended for having to miss the previous meeting and for not making this report available at an earlier date.

HJR 50: Involuntary commitment process and costs
Current use of MCA 53-21-126 by many county attorneys for determination of whether a petition for commitment (MCA 53-21-121) should be filed with the court appears to focus only on 53-21-126 (1) (b) or (c), with the latter interpreted the same as (b). A statement by the county attorney at the Commttee hearing of June 26-27 was inferred by me and others to mean that the KGF Supreme Court decision forces county attorneys to be more strict in their decisions regarding filing petitions for involuntary commitment. Anita Roessman made the KGF decision available to me. Nowhere in the thorough and extensive legal research and decision do I find any reference to interpretation of 53-21-126. The KGF decision appears to relate to the function of the respondent's attorney in adequate preparation for the commitment hearing and advocacy for the respondent's wishes and preference, as well as the attorney and the court protecting the respondent's constitutional civil rights. One has reason to expect that the county attorney should allow the court to decide whether the commitment is appropriate and as to whether community commitment is more appropriate than hospitalization rather than determining whether to file only if the conditions are sufficiently severe to require hospitalization. To do otherwise puts the providers in a serious situation ethically and perhaps legally when the patient is hospitalized, if releasing the patient from the hospital poses a risk and retaining them in the hospital becomes illegal retention.
Community involuntary commitment can prevent the need for hospitalization and concurrently help to reduce the probability of the illness becoming more severe and requiring longer to stabilize and control. 53-21-127 (3) (b) provides for such a post trial disposition. The concern expressed about poor treatment compliance can be addressed by intensive case management such as the Program for Assertive Community Treatment (PACT)., with the treatment team assisting the patient in understanding the effort to prevent hospitalization and to allow for community living. PACT has already demonstrated effective work with patients in reducing the need for hospitalization. This is cost effective compared to hospitalization as well as allowing the individual community living. This alternative means of helping individuals with serious mental disorder necessitates a complete understanding and utilization of the involuntary commitment statutes as well as proper acceptance of co-occurring disorders.
Please consider an amendment added to 53-21-126 (1): (e) Each of (a), (b), (c) or (d) shall be considered separately as cause for involuntary commitment.
Concommitantly, please consider my report of May 14, 2008 pertaining to the LJIC meeting of April 10-11, 2008. When used properly the involuntary commitment process is for the purpose of helping people get control of their illness, not to put unnecessary restraints on their activity.
Use of community commitment should have a more efficient means of helping patients who discontinue compliance and require hospitalization without having to go through the entire commitment process again.

Regarding the 14 day alternative program the clinical benefit is that many individuals have the illness stabilized in that time so are able to continue in outpatient treatment. However, funding for such a program for the patient who accepts this voluntarily must be available. The costs must not be left on the providers. This again brings forth the determination as to whether the state or individual counties are responsible for the costs, which must include medications and laboratory expense as well as the general costs.

As was previously stated regarding suicide prevention in jails and prison, protocol must require training for the staff. Such training can be available for low cost.

Donald Harr, M.D.

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Sent: Thursday, May 15, 2008 10:32 AM
Subject: Fw: Report-LJIC

----- Original Message -----
From: S&D Harr
To: Sheri Heffelfinger
Sent: Wednesday, May 14, 2008 10:42 PM
Subject: Report-LJIC

Report to Law & Justice Interim Committee: Meeting April 10-11, 2008

In-state residential treatment for youth:

Comments made Thursday morning regarding the need for less restrictive regulations than required for adults to allow youth to receive commitment proceedings deserves more explanation. The opportunity for youth with serious mental disorders to receive treatment before the condition reaches the level required for adult involuntary commitment can reduce the probability of more chronic illness that would necessitate more extensive and costly treatment later. This has been verified by research. My opinion is having adequate inpatient treatment facility available in-state will allow for more accountable effective treatment, not only because of better monitoring data but also having better access to working with involved families. Other than the benefit to patients and families, the possible long range fiscal savings compared to initial investment would have to be calculated.

Involuntary commitment process:

My first concern is the lack of consistency in the interpretation and implementation of the relevant statute regarding Trial or Hearing on petition (53-21-126). In (1) (c) the wording is "imminent threat of injury" not "threat of imminent injury". This was discussed recently with Thomas Towe, Esquire, former state senator in the 70's. He worked with Bryce Hughett, M.D. and me to re-write the commitment statute after the new Montana Constitution was approved. Although he does not recall te exact words we spoke, he remembers our extended conversation that the word "threat" did not indicate only that an act was essentially imminent to occur, but rather was realistically planned to happen. For many years the Yellowstone County Attorney's office and the District Judges accepted that interpretation without respondents improperly or illegally receiving involuntary commitments for treatment they needed. The respondents were represented by a very competent attorney who was knowledgeable about the statute. Failing to recognize that the respondent's physical liberty rights are protected by the statute and by the court's rulings seems to have led to an imbalance of the individual's right to necessary treatment and the right to physical liberty. This results in medically indicated requests for hearings being denied. There is no logical reason for this statute be "pitting law against medicine" as was stated. Both are supposed to be working for the people who are ill. Also, if the mental illness is the basis of a recommendation for involuntary commitment, the presence of a co-occuring condition should not be allowed to be the reason to deny filing for the hearing. Additionally, serious depressive disorders involve brain disorder as do other serious mental illnesses; people with such conditions deserve a hearing when the condition meets the criteria. Serious depressive disorders increase the risk of suicidal propensity more than other illnesses do. These issues indicate the need for a program of educating county attorneys and other involved authorities about mental illness to encourage a more open understanding of the statute.

In (1) (d) the stipulations allow for involuntary commitment to outpatient treatment when hospitalization is not necessary but medical history indicastes hospitalizatiion will be expected because of the deteriorating condition. If deemed necessary for clarification to meet requirement of the court, the last sentence of this part could be amended with the addition following "--respondent's medical history," with "including repeated hospitalizations and length of stay, severity of previous illness episodes, and refusal to comply with treatment plans, including prescribed medication". Adequate case management would encourage compliance as has been demonstrated with current intensive case management programs. Research has shown that multiple recurrent episodes of serious illness increases the severity of the illness and diminishes response to treatment, thereby extending treatment time and expense.

Opportunity for voluntary admission with preadmission screening to the state hospital can reduce the number